CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 575

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 3, 2005

Change Request 3679

NOTE: Transmittal 571 dated May 27, 2005, is being rescinded and replaced by Transmittal 575, dated June 3, 2005.

SUBJECT: New Remittance Advice (RA) Message for Referred Clinical Diagnostic/Purchased Diagnostic Service Duplicate Claims

I. SUMMARY OF CHANGES: This instruction is being re-issued to correct the description of Remark Code N347 in business requirement 3679.1 All other material remains the same.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : July 1, 2005

IMPLEMENTATION DATE : July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	N/A

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

One-Time Notification Attachment

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 575	Date: June 3, 2005	Change Request 3679

NOTE: Transmittal 571, dated, May 27, 2005, is being rescinded and replaced by Transmittal 575, Dated June 3, 2005.

SUBJECT: New Remittance Advice (RA) Message for Referred Clinical Diagnostic/Purchased Diagnostic Service Duplicate Claims

I. GENERAL INFORMATION

A. Background: Effective April 1, 2005, the Common Working File (CWF) will implement a new edit to check for duplicate claims for referred clinical diagnostic laboratory and purchased diagnostic services submitted by physicians/suppliers to more than one carrier. (See Transmittal 124, Change request 3551, published on October 29, 2004.) This new edit will be constructed to identify as duplicates of previously paid claims those claims submitted for referred clinical diagnostic/purchased diagnostic services when **all** of the data matches on the following claim fields **and** the claims contain different carrier numbers:

a. Beneficiary Name
b. Beneficiary Health Insurance Claim Number (HICN)
c. Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code
d. Date of Service
e. CPT/HCPCS Code Modifier

NOTE: Referred clinical laboratory services are identified for processing purposes by the presence of a "90" modifier. When performing the data matching, the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic services will not include the "90" modifier on referred laboratory claims in the matching criteria, but will perform matching on all other criteria specified above.

The CWF duplicate claim edit will only apply to claims containing a CPT code that is included on the clinical laboratory fee schedule, or a HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations to be implemented in April 2005.

Effective with the implementation of this new edit, the CWF will reject a claim for a referred clinical diagnostic/purchased diagnostic service when it identifies the claim as a duplicate of a previously paid claim, using the above matching criteria. The edit will identify as duplicate claims only those claims that match on all of the above data elements when the claims contain different carrier numbers. Claims with matching data elements but the same carrier number will not be subject to this edit. The existing edits for identifying suspected duplicate claims will continue to apply.

Carriers have been instructed to deny the appropriate claim lines when claims are rejected by the CWF duplicate claim edit, and to use the most appropriate duplicate claim messages on the remittance advice notices and Medicare summary notices (MSN) generated for these claims. (If the carrier later determines that a referred clinical diagnostic/purchased diagnostic claim rejected by CWF is not a duplicate of another claim submitted for the same service, and that the service is allowable, the carrier has been instructed to use the CWF override code to allow payment.)

B. Policy: The Centers for Medicare and Medicaid Services (CMS) is establishing a new remark code to be included on the remittance advice notice generated for referred/purchased diagnostic service claim items denied due to the CWF duplicate claim edit for referred/purchased service claims. Effective for claims processed on or after July 1, 2005, carriers must use the following remark code on a remittance advice notice(s) generated for a referred clinical diagnostic/purchased diagnostic service claim line item(s) denied as a duplicate(s) of a previously paid service(s):

Remark Code N347 – Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.

In addition, carriers must use the following duplicate claim message on the Medicare Summary Notice generated to the beneficiary when a claim line(s) is denied due to the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic services:

7.1 - This is a duplicate of a charge already submitted.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3679.1	Effective for claims processed on or after July 1, 2005, carriers shall use the following remark code on the remittance advice notice(s) generated for a referred clinical diagnostic/purchased diagnostic service claim line(s) denied as a duplicate(s) of a previously paid service(s): Remark Code N347 – Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.			X			X			
3679.2	Carriers shall use the following duplicate claim message on the MSN generated to the beneficiary when a claim line item(s) is denied due to the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic services: 7.1 - This is a duplicate of a charge already submitted.			X			X			

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Bridget Wilhite at Bridget.Wilhite@cms.hhs.gov and Joan Proctor-Young @ Joan.Proctor-Young@cms.hhs.gov. **Post-Implementation Contact(s):** Contact the appropriate regional office.	**Medicare contractors shall implement these instructions within their current operating budgets.**

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